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UNCLAS SECTION 01 OF 04 PRETORIA 004947

SIPDIS

DEPT FOR AF/S; AF/EPS; AF/EPS/SDRIANO
DEPT FOR S/OFFICE OF GLOBAL AIDS COORDINATOR
STATE PLEASE PASS TO USAID FOR GLOBAL BUREAU APETERSON
USAID ALSO FOR GH/OHA/CCARRINO AND RROGERS, AFR/SD/DOTT
ALSO FOR AA/EGAT SIMMONS, AA/DCHA WINTER
HHS FOR THE OFFICE OF THE SECRETARY,WSTEIGER AND NIH,HFRANCIS
CDC FOR SBLOUNT AND EMCCRAY

E.O. 12958: N/A
TAGS: ECON KHIV SOCI TBIO EAID SF
SUBJECT: SOUTH AFRICA PUBLIC HEALTH NOVEMBER 12 ISSUE

Summary

¶1. Summary. Every two weeks, USEmbassy Pretoria publishes a public health newsletter highlighting South African health issues based on press reports and studies of South African researchers. Comments and analysis do not necessarily reflect the opinion of the U.S. Government. Topics of this week's newsletter cover: financing of shift to primary health care to provinces; obesity as a problem in Africa; Cape study shows most addicts share needles; real health care spending 4.8 percent lower in 2003; increasing welfare grants crowd out other government expenditures; alcohol-related sexual risk behavior study released; shortage in health staffing; AIDS drugs needed for South African HIV-positive children; and South African insurance companies remove HIV exclusion clauses. End Summary

Treasury Questions Shift of Primary Health Care to Provinces
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¶2. Under the National Health Act, expected to begin in the 2005-06 financial year, provincial health departments are to take over responsibility for primary health care, which they can then delegate to local authorities. The act's intention is to consolidate fragmented primary health-care services under a single level of government, and will leave local government responsible only for environmental health services. The act will also mean that the national treasury will replace local government as the funder of primary health-care services, via increases to the equitable share form of grant funding given to provinces. But a senior treasury official said that the health department was being urged to discuss alternative arrangements with the metropolitan areas. The six metropolitan councils of Johannesburg, Tshwane (Pretoria), East Rand, Cape Town, Durban and Nelson Mandela (Port Elizabeth) currently account for about R700 million of the R1 billion annual primary health-care spending, which they fund from local taxes. Primary health-care facilities include clinics, community health centers and some hospitals. Treasury's health policy director, Mark Bletcher, said one option was to make the metropolitan authorities responsible for primary health care and fund them directly. Another possibility would be for the metros to run the services and provide top-up funding above a norm supplied via the provinces. Bletcher also said February's budget would include allocations to the nonmetropolitan areas via the equitable share, starting with about R200m in 2005-06, and rising to R300m in 2006-07 and R400m in 2007-08. The Department of Treasury was concerned about the ability of some of the weaker district councils to manage the primary health care transition. Source: Business Day, November 1.

Obesity a Problem in Africa

¶3. The first international obesity conference in Africa highlighted the health problems associated with overweight adults and pointed out that Africa suffers health impacts from obesity as well as the rest of the world. There are over 300 million overweight adults worldwide, suffering from weight-related illnesses like diabetes, heart disease and sleeping disorders. One in three South Africa males and over one in two adult women are overweight. In Morocco, 40 percent of the population is overweight, while in Kenya it is 12 percent. In Nigeria, 6 to 8 percent of people are obese. Obesity has created a double burden in parts of Africa still struggling to overcome malnutrition. Obesity among the young was pointing to a large increase in type 2 diabetes. The spread of AIDS dissuades people from losing weight. AIDS is nicknamed "slim" (thin) throughout Africa as victims waste away. People do not want to lose weight in case others think they have HIV. About 25 percent of people living in the Middle East are overweight, while obesity has doubled among Japanese men since 1982. Children around the world are also growing obese, with the fattest children living in the Middle East, Chile, Greece and southern Italy. Source: The Cape Times, November 2.

Cape Study Shows Most Addicts Share Needles

¶4. Between 12,000 and 18,000 Capetonians are addicted to heroin and almost all those who inject the drug share needles, according to a recent report by the Medical Research Council (MRC) on drug use in South African cities. The report found that escalating numbers of Capetonians are seeking help for addiction to heroin and to tik (methamphetamine), which was hardly in use four years ago. An MRC study conducted in July and August found that around a quarter of heroin addicts in treatment centers in Cape Town had been injecting the drug and four out of five had shared a needle within the previous 30 days. Two years ago only one percent of all those getting treatment at the centre were addicted to tik. Last year it increased to five percent and this year to at least 40 percent. The study found that a quarter of all addicts receiving treatment in the city use tik as their main or secondary drug. Source: Cape Times, November 1.

Real Health Care Spending 4.8 Percent Lower in 2003

¶5. The South Africa Survey shows that healthcare spending in 2003 was 4.8 percent lower in real terms than in 1996, with large inequities still existing between the provinces. Some provinces spent as little as 75 rand ($1.23 using 6.1 rands per dollar) per capita per annum, where the government goal is 200 rand. Two of the provinces with the highest HIV/AIDS infection rates, Gauteng and Mpumalanga, failed to spend all the money allocated to them in conditional grants to fight the pandemic in 2002/03. Gauteng spent only 52 percent of its funds, while Mpumalanga spent only 38 percent. In 1995 an estimated 85 percent of companies were providing benefits to their pensioners, while in 2003 this number had fallen to only 43 percent. The government increased the value of the old-age social pension by 13 percent between April 2002 and April 2003. During the same period, the number of beneficiaries of child support grants increased by 45 percent. Between 1997 and 2003, the number of welfare grant beneficiaries in South Africa grew by 124 percent from 2.5 million to 5.6 million. Source: I-Net Bridge, November 3.

Increasing Welfare Grants Crowd Out Other Government Expenditures
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¶6. Welfare grants will comprise over 40 percent of the government expenditure increases for the next three years. Finance Minister Manuel allocated R20.8 billion ($3.4 billion using 6.1 rands per dollar) of the R50 billion ($8.2 billion) for welfare grants. Two million people were added to the beneficiary lists for various grants between April and September this year alone, pushing the total number of recipients to nine million, about one in five of the total population. Much of the increase was in the unexplained escalation in disability and foster care grants, which Manuel said was most likely due to poor administration. Manuel said that in some provinces, officials were adding applicants to the list without any checks, families were registering their own children as foster children and government officials were illegally claiming childcare support for their own children. The government has no figures on the number of people claiming disability grants as a result of HIV/AIDS and there are no firm guidelines on their eligibility. In addition, there are plans to raise the ceiling for child grants from 10 to 13 years through 2008. Welfare grant administration will be shifted to a national social welfare agency in 2006, but Manuel moved this week to limit the damage to other services by shifting welfare funds from the equitable share paid to provinces to the conditional grants that go to these regional governments. The change would mean that overruns would be the responsibility of the national department even though distribution would remain a provincial responsibility until March 2006. At present, welfare claims take precedence over other provincial expenditure. Provinces have had to cut back on critical health and education budgets or have taken out bank overdrafts to pay welfare grants expected to total R38.4 billion ($6.3 billion) in the current financial year, rising to R47 billion ($7.7 billion) in the 2007/08 fiscal year. In the financial year through March 2004, Northern Cape overspent on welfare grants by 8.6 percent, KwaZulu-Natal by 7.2 percent, Eastern Cape by 7.7 percent and Gauteng by 4.1 percent. Western Cape and North West provinces under spent in this regard. Source: Business Times and I-Net Bridge, November 3.

Alcohol-related Sexual Risk Behavior Study Released

¶7. The Medical Research Council (MRC) released a report investigating alcohol-related sexual risk behavior, funded by the World Health Organization. The study included qualitative assessments involving interviews and focus groups, developing in-depth questionnaires and finally testing the survey using 160 24-44 adults in two townships and one city in Gauteng. Key findings were: (1) Alcohol use was widespread among adults in the 25-44 year age group. Although less likely to drink,

females were more involved in risky drinking (defined as 5 or more drinks per day for males and 3 or more drinks for females); (2) Sexual gender differences exist; males were more likely to have younger and multiple sexual partners and use condoms, while females were more likely to have older partners and view sexual intercourse as safer with older men; (3) Access to condoms and knowledge about HIV infection due to multiple sexual partners were high, but condom use was not. Condom use was more common with a casual rather than a regular sexual partner; (4) Sexual risk behavior was identified as one of the consequences of heavy drinking; and (5) there was no correlation between various alcohol use variables and condom use. The research suggests that reductions of heavy alcohol consumption and sexual risk behavior should be targeted to families and communities as well as individual treatment. Treatment should reduce opportunities and demand for heavy drinking, leading to possible reductions in sexual risk behaviors. Source: www.sahealthinfo.org, November 1.

Shortage in Health Staffing

¶8. According to Health Systems Trust's (HST) 2003-04 South African Health Review, 31.1 percent of health posts in the public sector were vacant between 2001 and 2003, and health care vacancies differed widely among provinces, with 67.4 percent of Mpumalanga's posts vacant, 13.4 percent in Limpopo and 13.8 percent in Western Cape. HST asserts that the migration of graduates to other countries is probably the largest contributor to the shortage of health care professionals. In addition, the introduction of the rural and scarce skills allowances this year, designed to attract health professionals to the public sector and keep them there, had limited success in increasing the supply of personnel in underserved areas. The number of medical graduates involved in community service has declined. To increase black health professionals, Health Professions Council of SA registrar Boyce Mkhize called for equity targets to be set for training institutions, and suggested there be broadened criteria for the admission of black students, asserting that many blacks were excluded due to poor matric grades from poorly resourced schools. The Council's statistics show that only 23,419, or 22 percent, of the 104,463 health professionals registered with it describe themselves as black or African, and when those describing themselves as Asian (5491) and coloured (1708) are added, the percentage is only 25 percent. But new registrations of black, coloured and Asian professionals have increased to 70.2 percent this year, from 42.7 percent in 2000. Since 1998, most of South Africa's eight medical universities have used "alternative admissions tests", which take non-academic criteria into account in an effort to increase admissions of black students. In 2003, 45 percent of first year medical students were black, about 10 percent coloured, 15 percent Indian and 30 percent white. Source: Business Day, November ¶5.

South Africa: AIDS Drugs Needed for HIV-positive Children

¶9. Although there is no separate national target, the number of children currently receiving ARVs is low. The AIDS lobby group, Treatment Action Campaign (TAC), recently conducted a survey in 13 of KwaZulu-Natal's largest public hospitals and found that only 39 children were receiving anti-AIDS medication. According to Dr Neil McKerrow at Grey Hospital in Pietermaritzburg, the province's unofficial target is to have 2,000 children on ARV treatment by March 2005. The national treatment plan, unveiled last November, initially targeted the treatment of 53,000 people by March 2004, which has since been extended to March 2005. Efforts to establish the national status of the ARV rollout for children were difficult, as the National Department of Health would not disclose the number of children on treatment in the public sector. Nevertheless, doctors and healthcare workers are still debating at what age a child should start taking ARVs. Under South African law, a child younger than 14 years requires consent from a parent or guardian to be given the drugs, but TAC is saying the 'right age' cannot be regulated by government and should be assessed by doctors on a case-by- case basis. Another obstacle to providing free drugs to children is the prohibitive cost of specialized tests for diagnosing HIV in children younger than 18 months. The most commonly used HIV antibody test, the rapid test, is unable to discern between maternal and child antibodies in infants. Because HIV antibodies can cross the placenta and stay in a child's bloodstream for 15 months, a baby needs a Polymerase Chain Reaction (PCR) test, which can detect small quantities of viral protein in the blood, to establish their status. This test is not widely available and is substantially more expensive than rapid tests. Adult ARVs are available to children above three years of age, with specific formulations and dosages based on age and weight. Despite pediatric syrup having been made more widely available over the last few months, not all caregivers, particularly those living in remote rural areas, have the refrigeration facilities needed to store the medication. The adherence of children to the drugs is another challenge. According to Noreen

Ramsden from the Children's Rights Centre in Durban, only 70 percent of children adhered to the treatment plan. Orphaned children in child-headed households in both urban and rural areas, who lack supportive care and proximity to treatment centers, find it even more difficult to access the drugs. Source: PLUSNEWS, November 3, hst.org.za; UN Integrated Regional Information Networks, November 5.

Insurance Companies Remove HIV Exclusion Clauses

¶10. South Africa's R163.8 billion ($26.9 billion using 6.1 rands per dollar) insurance industry could drop HIV/AIDS exclusion clauses on all new policies starting January 2005. The Life Offices' Association (LOA) is expected to issue a statement to this affect just after its annual general meeting on November 19, when the issue will be put to the vote. Already some insurance companies have dropped HIV/AIDS exclusions from certain products in anticipation of the agreement. African Life last week removed all HIV/AIDS exclusions on its new and existing burial policies and Old Mutual, the country's largest life insurer, removed one of its few remaining HIV exclusions by scrapping the clause from its premium waiver cover on newer life and investment products. Gerhard Joubert, the executive director of the LOA, said that the removal of the exclusion clauses effectively placed HIV/AIDS equal to any other medical condition as far as long-term insurance policies were concerned. For most insurance companies, this will mean that applicants who initially tested HIV-negative would have to be paid out in full even if the eventual cause of death is AIDS-related. While insurance companies may still require HIV testing, they would no longer be allowed to deny new applications from those who test HIV-positive. Joubert said on average 5 percent of applicants for long-term insurance risk products were HIV-positive. Source: Business Report, November 9.

FRAZER